PATIENT NAME: _____

FOR OFFICE USE ONLY:

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VITALS:

HT:	
WT:	
BP:	
PULSE:	
SMOKING HX:	

New Patient Information Questionnaire

Page 1: Reason for Visit

How old are you?	years old
Gender:	☐ Male ☐ Female
Hand-Dominance:	☐ Right ☐ Left ☐ Ambidextrous
My pain is on the:	☐ Right ☐ Left ☐ Both sides

What is the reason for Today's Visit? *Please give complete details of your symptoms*

Location
Quality
Severity
Duration
Timing
Context
Modifying Factors
Associated Signs & Symptoms

Was this the result of an accident?

What treatments have you had?

I have reviewed this document in its entirety with the patient.

Physician Signature_____ **Date**_____

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Page II: Medications and Allergies

List your drug allergies (if any)

☐ NO KNOWN DRUG ALLERGIES	
Drug Name	**Allergic Reaction**

List your medications. *Please include all supplements, herbals, and alternative treatments*

Drug Name	Dose	Taken How Often?	Date Last taken

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Page III: Past Medical History

List of common conditions (check all that apply)

	Heart		***Lungs***
☐	High Blood Pressure	☐	Asthma
☐	High Cholesterol	☐	Emphysema/Chronic Bronchitis/COPD
☐	Previous Heart Attack	☐	Sleep Apnea
☐	Congestive Heart Failure	☐	Pneumonia (When? _____)
☐	Atrial Fibrillation or other Arrhythmia	☐	Pulmonary Embolism
☐	Heart Murmur		***Joints / Musculoskeletal***
☐	Chest Pain	☐	Degenerative Arthritis or Osteoarthritis
☐	Stress Test (When? _____)	☐	Rheumatoid Arthritis
☐	Echocardiogram (When? _____)	☐	Lupus
	Brain and Nervous System	☐	Psoriatic Arthritis
☐	Previous Stroke or TIA	☐	Ankylosing Spondylitis
☐	Alzheimer's or other Dementia	☐	Fibromyalgia
☐	Multiple Sclerosis	☐	Osteoporosis
☐	Epilepsy or Seizures		***Endocrine***
☐	Parkinson's Disease	☐	Diabetes
	Gastrointestinal	☐	Hypothyroid
☐	GERD/Esophageal reflux/gastritis	☐	Recently took Prednisone
☐	Stomach Ulcer		***Vascular / Heme***
☐	Liver Disease	☐	Previous Blood Clot
☐	Bleeding from stomach or colon	☐	Previous Blood Transfusion
☐	Colonoscopy (When? _____)	☐	Anemia
	Dental	☐	Varicose veins
☐	Loose Teeth	☐	Bleeding problems
	Psychiatric / General	☐	Cancer (Specify: _____)
☐	Anxiety		***Kidneys***
☐	Depression	☐	Kidney Disease
☐	Chronic fatigue	☐	Dialysis
		☐	Urinary Tract Infections
		☐	BPH
		☐	Incontinence

Please list all other medical conditions:

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Page IV: Past Surgical History and Hospitalizations

Please list all of the operations that you have had and any complications of anesthesia

Operation	Date	Hospital	Anesthesia Complications (if any)

Have you ever been to the Emergency Room or admitted to the Hospital for medical reasons?

Date	Hospital	Reason for ER Visit or Hospitalization

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Page V: Family Medical History and Social History

Family Medical History

Relation	Deceased?	Medical Problems
Mother		
Father		
	How many?	
Brothers		
Sisters		
Sons		
Daughters		
	Specify Relation	
Other Relatives		
Other Relatives		

Social History

What is your marital status?	
Do you have children (if so how many)?	
Are you working now?	
What is (or was) your occupation?	
Have you ever smoked cigarettes?	
If yes: How many packs a day?	
At what age did you start smoking?	
Do you smoke now?	
If no: At what age did you stop?	
Approximately how many drinks of alcohol do you consume in a week?	
Who do you live with?	
Where were you born?	
If outside the U.S.: When did you immigrate?	
Do you have stairs at home?	
Have you used illicit drugs?	
If yes: Which drugs and how recently?	

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Page VI: Review of Systems

Check all that Apply

General
- ☐ I get tired easily
- ☐ I have night sweats
- ☐ I have fever and/or chills
- ☐ I have recently gained weight
- ☐ I have recently lost weight
- ☐ I have a poor appetite

Eyes
- ☐ I wear glasses or contact lenses
- ☐ I have blurry vision or changes in my vision
- ☐ I have eye pain

Ears, Nose, Mouth & Throat
- ☐ I have ringing in my ears
- ☐ I have hearing loss
- ☐ I have frequent nosebleeds
- ☐ I have seasonal allergies
- ☐ I have nasal congestion
- ☐ I have frequent post-nasal drip
- ☐ I have bleeding gums
- ☐ I have dentures
- ☐ I have jaw pain
- ☐ I have loose teeth
- ☐ I have a hoarse voice
- ☐ I have neck pain
- ☐ I have neck stiffness
- ☐ I have swollen glands in my neck

Respiratory
- ☐ I have a cough
- ☐ I am short of breath when resting
- ☐ I am short of breath when walking
- ☐ I have had Tuberculosis
- ☐ I have frequent wheezing

Neurological
- ☐ I have frequent headaches
- ☐ I have seizures
- ☐ I have dizziness
- ☐ I have a tremor
- ☐ I have numbness and tingling
- ☐ I faint frequently

Psych/Mood
- ☐ I feel depressed
- ☐ I am anxious
- ☐ I have difficulty concentrating
- ☐ I have difficulty sleeping
- ☐ I have mood swings
- ☐ I have hallucinations

Cardiac
- ☐ I have chest pains
- ☐ I have palpitations
- ☐ I have a murmur
- ☐ I have swelling in my legs
- ☐ I can not sleep lying flat

Gastro
- ☐ I have belly pain
- ☐ I have a mass in my belly
- ☐ I have regular heartburn
- ☐ I have trouble swallowing
- ☐ I have frequent nausea and vomiting
- ☐ I have diarrhea
- ☐ I have constipation
- ☐ I have blood in my stool
- ☐ I have a hernia

Kidney
- ☐ I have painful urination
- ☐ I have very frequent urination
- ☐ I am incontinent of urine
- ☐ I have blood in my urine

Musculoskeletal
- ☐ My joints are stiff
- ☐ My joints are swollen
- ☐ I have joint pain
- ☐ I recently broke a bone
- ☐ I have muscle pain

Skin
- ☐ I have a rash

Endocrine
- ☐ I am very thirsty and urinate frequently
- ☐ I am anxious
- ☐ I have hair loss

Heme/Lymph
- ☐ I bruise easily
- ☐ I have had blood clots
- ☐ I have swollen glands

Additional Comments:

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Page VII: Special Medical Conditions

Please check No/Yes even if these conditions were already described elsewhere on this form

Have you had an **MI** (Myocardial Infarction or **"Heart Attack"**) in the past 6 months?	☐ No	☐Yes
Have you ever undergone an **Angiogram** or **Cardiac Catheterization** procedure?	☐ No	☐Yes
If YES, was a **Stent** placed? How Many? _____	☐ No	☐Yes
Do you have a history of **CABG** or **Bypass** surgery?	☐ No	☐Yes
Do you have a history of significant **Valvular Heart Disease**?	☐ No	☐Yes
Do you have a history of **Heart Failure**?	☐ No	☐Yes
Do you have a history of Cerebrovascuar Disease, **Stroke** or **TIA**?	☐ No	☐Yes
Do you have a history of Diabetes treated with **Insulin**?	☐ No	☐Yes
Do you have a history of **Kidney Disease**?	☐ No	☐Yes
Are you on **Dialysis**?	☐ No	☐Yes
Do you have a history of **Cirrhosis**?	☐ No	☐Yes
Do you have an Active **Cancer** or are you currently receiving **Chemotherapy** or **Radiation**?	☐ No	☐Yes
Have you been previously **diagnosed** with **Sleep Apnea**?	☐ No	☐Yes
Do you use a **CPAP** machine?	☐ No	☐Yes
Do you use **Oxygen** at home?	☐ No	☐Yes
Do you have a history of **Blood Clots** (**DVT** or **Pulmonary Embolism**)?	☐ No	☐Yes
Do you have a **Pacemaker** or a **Defibrillator**?	☐ No	☐Yes
Are you taking a steroid medication such as **Prednisone**?	☐ No	☐Yes
Do you have **HIV**?	☐ No	☐Yes
Do you have any **Loose Teeth**?	☐ No	☐Yes
Are you taking any **Blood Thinners** ? (for example: aspirin, Coumadin, warfarin, Pradaxa, Plavix, Xarelto)	☐ No	☐Yes
Have you ever had a **GI** (gastrointestinal) **Bleed**?	☐ No	☐Yes